EDUCATORS

FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT FORM

852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7475 • 800-662-5851 • Fax: 801-270-3062

I. EMPLOYEE INFORMATION SECTION

EMPLOYEE NAME	SS#	EMPLOYER

☐ Check here if new address

STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE #	WORK PHONE #		

II. HEALTH CARE REIMBURSEMENT SECTION

DATES OF SERVICE	NAME OF PATIENT	RELATIONSHIP TO INSURED	DESCRIPTION OF SERVICES	REIMBURSABLE AMOUNT
				$
				$
				$
				$
				$
			TOTAL REIMBURSABLE AMOUNT	$

III. DEPENDENT CARE REIMBURSEMENT SECTION

DATES OF SERVICE FROM	TO	DEPENDENT(S) NAME	AGE	RELATIONSHIP TO INSURED	PROVIDER NAME, ADDRESS, and TIN or SSN	REIMBURSABLE AMOUNT
						$
						$
						$
						$
					TOTAL REIMBURSABLE AMOUNT	$

IV. SIGNATURE

I certify that I have not been reimbursed for the above expenses and that I will not seek reimbursement under any other plan covering health benefits and that the expenses will not be claimed as an income tax deduction. I am requesting reimbursement only for qualifying expenses incurred during the plan year for eligible plan participants. I authorize my Flexible Spending Accounts to be reduced by the amounts requested.

X _____ Date _____

NOTE: Please attach supporting documentation (receipts, billing statements, etc.). A separate form for each receipt is not necessary. Claims will not be processed without completed information and supporting documentation. Supporting documentation will not be returned. Therefore, be sure to keep copies of these expenses for your records.

1. Definitions:

   The terms listed below shall have the following meanings on the reimbursement form:

   a. **Employer** - sponsoring group or district with which participant is employed.

   b. **Description of Services** - i.e., Dental = cleaning, filling, crown, etc.
      Surgery = gall bladder removal, etc.

2. Supporting Documentation:

   Including, but not limited to the following:

   a. Health Care (medical, dental, vision, prescription)

      1. Receipt, billing, or prescription stub. These must show date of service, description of service/product, amount to be reimbursed, and provider name. If a receipt for eligible over-the-counter medications does not contain all of the required information, include the box top showing drug name and cost, along with the cash register receipt.

      2. Printouts from the pharmacy for prescription services must include the pharmacist's signature.

      3. Canceled checks, copies of cancelled checks, and credit card receipts are not acceptable documentation.

   b. Dependent Care (child care, elderly care)

      1. Receipt, billing, processed documentation. These must show dates of service (both beginning and ending date), amount to be reimbursed, provider name, provider signature, provider's TIN or SSN, and provider address.

Supporting documentation will not be returned.
Therefore, be sure you have copies of these expenses for your records.

3. Submitting Claims:

   a. All completed claim forms, with supporting documentation attached, must be sent to

      EDUCATORS FLEXIBLE SPENDING DEPARTMENT
      852 East Arrowhead Lane
      Murray, Utah 84107-5298